



Student Health Clinic and Immunizations Office
Division of the Wellstar College of Health and Human Services

Travel History Form

Complete this form **BEFORE** your appointment

Date of Appointment: _____ Student ID #: _____

Name: _____ Date of Birth: ____/____/____

Telephone #: _____ Email: _____

_____ Male _____ Female Cell Phone: _____

Do you have a current passport or visa: _____ Yes _____ No _____ Don't know

Travel Specifics

Purpose of trip: _____ School related Study/Work what program? _____

_____ Pleasure _____ Work _____ Other: _____

What will you be doing on this trip: _____

Does your program require completion of a medical form by a practitioner?

_____ Yes _____ No

Are you currently enrolled in a health insurance plan that covers you while outside the United States?

_____ Yes _____ No

What insurance coverage do you currently have: _____

Departure date from the US: _____ Return date to US: _____

Countries AND cities to be visited in order of visits	Arrival Date	Departure Date



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Name: _____ DOB: ____/____/____ Student ID#: _____

Have you ever traveled outside the US before? _____ Yes _____ No

If yes, where and when: _____

Will you be:

____ Yes _____ No Visiting ONLY urban areas?

If No, explain: _____

____ Yes _____ No Staying ONLY in hotels?

If No, explain: _____

____ Yes _____ No Visiting family and friends?

____ Yes _____ No Ascending to high altitudes (>7,000 ft. or 2,300 meters) in the mountains?

____ Yes _____ No Working in the medical field with exposure to blood or other bodily fluids?

____ Yes _____ No Working with exposure to animals?

____ Yes _____ No Potentially have sexual contact with new partners?

Allergies

____ No known drug allergies _____ No known food allergies

Have you ever had a reaction to any of the following? (Please check all that apply)

- ____ Eggs
- ____ Sulfa drugs (e.g. Bactrim, Septra etc.)
- ____ Antibiotics (e.g. Streptomycin, Neomycin etc.)
- ____ Thimerosal (preservative in contact lens solution)
- ____ Chrysanthemums
- ____ Quinines (Chloroquine, Meflaquine etc.)
- ____ Pyrimethamine
- ____ Tetracycline (Doxycycline etc.)
- ____ Other: _____

Were you born in the United States: _____ Yes _____ No, where? _____

Are you using steroids, receiving radiation therapy or other immunosuppressive chemotherapy? ____ Yes ____ No

List your current prescription medications and medical condition treated: (include birth control pills)

Current prescription medications	Condition or reason for use

List regularly used non-prescription medications (over the counter herbal, homeopathic, vitamins etc.) OR supplements (like those purchased at GNC stores):

Regularly used Non-prescription medications or supplements	Condition or reason for use



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Name: _____ DOB: ____/____/____ Student ID#: _____

Have you been told you have any of the following medical conditions (check all that apply)

Yes	No	Family history		Yes	No	Family history	
			Anemia				High Blood Pressure
			Asthma				High Cholesterol
			Blood clotting Probs				Hormone Problems
			Cancer				Immune System Deficiency
			Depression				Kidney Disease
			Diabetes				Liver Disease/hepatitis
			Ear Infections				Lung Disease
			Eye Problems				Prostate Problems
			G6PD Deficiency				Psoriasis/skin issues
			Gout				Psychiatric Problems
			Hearing Problem				Sickle Cell Disease
			Heart Disease				Stroke
			Other				Thyroid Problems

For Female Patients only

Last normal menstrual period: _____

Are you, or could you possibly be pregnant? _____ Yes _____ No

Are you breastfeeding an infant? _____ Yes _____ No

Questions/Concerns

Please list additional questions or concerns that you might have regarding your travel:
